

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER

11391

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hosp</b>		Length of stay in lb <b>22</b>	
3. NAME OF DECEASED (Type or print) <b>Bartholomew (Bart) Long</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10 1892</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		9b. AGE (In years last birthday) <b>65</b>	
10a. KIND OF BUSINESS OR INDUSTRY <b>Cable Industry</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>	
13. FATHER'S NAME <b>John Long</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>494 03 5589</b>	
17. INFORMANT <b>Norine Long</b>		Address <b>3908 Gustine</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 yrs</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year p. m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>11-25-57</b> to <b>11-26-57</b> and last saw her/him alive on <b>11-26-57</b> Death occurred at <b>3:55 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. H. Luthien MD</b>		22b. ADDRESS <b>5600 S. Compton</b>	
22c. DATE SIGNED <b>11/27/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/29/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
24. FUNERAL DIRECTOR <b>E. J. Schnur</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 27 '57</b>	
ADDRESS <b>3125 Lafayette</b>		26. REGISTRAR'S SIGNATURE <b>J. C. Smith MD</b> <b>m 8 25</b>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed

*Thomas R. Jewell*

Licensed Embalmer No. 379-

P. O. Address 3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.